Too Little, Too Late for Female ER Patient

Article by A.L. DeWitt, JD, RRT, FAARC

from ***Advance for Respiratory Care Practitioners*** *June 26, 2006*

When lawyers try cases, they try them based on a "theme," a shorthand way of understanding the nature of the case. When the late Johnnie Cochran quipped, "if it doesn't fit, you must acquit," he distilled the theme of the O.J. Simpson case to a single sentence. That's what lawyers do. They take a two- or three-week case and break it down to a single sentence like "too little, too late."

Most of the time, when a theme is developed in a medical case, it comes out of the patient record. It is found in a statement by the defendant or a simple characterization of what happened. Sometimes it is as easily stated by saying what is not in the record as what is in the record.

When I started as a therapist, it was drilled into me that if you didn't chart it, you didn't do it. I've always applied that rule to both therapy and the law. With "innovations" in charting like electronic forms and hand-held, step-by-step charting solutions, I am amazed that documentation does not play a bigger role in lawsuits.

Recently I inspected the care of a 20-year-old respiratory patient from California. I rarely find fault with a therapist's care, mostly because therapists try their best and normally succeed in getting the patient taken care of. It is rare for therapists to fall down in charting or patient care. But it does happen, and I have a case that I think qualifies as one of the all-time worst respiratory care cases ever.

The patient, we'll call her Lucy, was seen in the ER after a long night of difficult breathing at her home. She had been diagnosed recently with asthma and was having the thick secretions and airway spasm so common in asthma patients. When she came to the emergency room, her blood gases showed respiratory acidosis, hypercapnia and hypoxemia. This was a sick patient.

With aggressive respiratory care and pulmonary toilet, she could have been discharged the next day. But delay, fatigue and error caused a different ending.

The physician originally ordered albuterol by nebulizer, and when that failed to break the spasm, he ordered continuous albuterol. Neither the original treatment nor the continuous treatment were documented. The order was transcribed on a respiratory sheet, but the therapists never noted giving the treatment. There was no record of breath sounds, no record of how the patient was breathing. No one paid any notice to the use of the accessory muscles. Instead of documenting her condition, the therapists just documented the order. Too little.

After an hour in the ER, Lucy's hypoxic respiratory failure worsened

and she required intubation and mechanical ventilation. There is no documentation of where the tube was taped. There is no documentation by the therapist at all. The nurse indicated that an ET tube was placed and its size. The patient was ventilated by hand, and at some point a ventilator was brought to the ER and hooked to the patient. There was not a bed available in the ICU at that time.

The patient presented in the last few minutes of one shift, and the first few of the next. The therapist leaving did not give report. The therapist coming on did not take it. The therapist who took over care went to the bedside and did a ventilator check. The check was a recording of all the numbers, with no narrative. The therapist did not record breath sounds or chest expansion.

She did not record suctioning, although the nurse recorded some suctioning had been done by the therapists. Incredibly, no one assessed tube placement.

As the patient became eligible for transport to the ICU, the therapist decided reintubation was necessary because the tube was "too short." Interestingly, there was not a note in the chart that indicated that the tube used was shorter than usual or had been cut at all.

The tube remained in place for 15 minutes while a physician was summoned to do the intubation. Immediately after the reintubation,Lucy lost breath sounds on the right and was diagnosed with a pneumothorax and pneumomediastinum.

Clinicians already know what happened. The tube was not "too short" (no one ever compared it against a standard tube to see). It appeared shorter than normal because it was forced into the right mainstem. The full ventilator volume was forced into one lung, and no one picked up on the situation. The patient suffered a pneumothorax as a result. That pneumothorax led to a drop in BP and to fatal dysrhythmias. Lucy lost her life because the therapist going off duty failed to document the tube position, and the therapist coming on failed to verify it. Too late.

We know it is not negligence to have a tube slip down. Things like that happen all the time. It is not negligence to intubate the esophagus either; it is negligence not to discover it, however. In this case, the chief allegation of negligence is that the tube was forced into the right mainstem bronchus and that positioning went undetected for a long enough time for a pneumothorax to develop. All kinds of indicators (like pressure limit, minute volume, etc.) should have clued the therapist to the problem.

Instead, it was the difficulty ventilating with the new tube and the fall in blood pressure that clued the code team to the true nature of the emergency. Even with a chest tube, Lucy could not be saved. A case of too little, too late.

The trial lawyer already has his theme: You can't wait to investigate.

That is what happened. Therapists waited to investigate. Nurses didn't investigate. The doctor was not notified until there was a code blue called. In the end, Lucy died because no one expected a tube to get malpositioned; yet no one documented anything that would have allowed the tube's position to be evaluated against a standard. Even though there were two chest X-rays that showed "good tube position," there was no contemporaneous charting to indicate where the tube was when the radiographs were taken. Without this, when the tube was discovered to be "too short," there was no way to know just how short it was.

When things are hopping, clinicians often operate under the theory that doing it is more important than charting it. This leads directly to the situation in this case where a therapist might have done the things but didn't chart them. As a result, the RT's defense is now marred by the passage of time and the failure to record vital information. It is difficult to convince a jury that you did everything right when: A. you didn't record it, and B you didn't give any indication you considered the problem. In fact, when the only charting you do is the numbers on a ventilator flow sheet, the absence of documentation most likely makes the situation almost impossible to remember. What can you testify to if all you have is numbers and no way to separate this patient, six years later, from every other code blue you've been to in the meantime?

Good documentation is done contemporaneously with the event. It records what happened, when it happened, who did it and why. It documents that the therapist behaved as a reasonable and prudent therapist. Documentation that fails to do that fails to protect you from a lawsuit later on.

A.L. DeWitt is affiliated with the law firm of Bartimus, Frickleton, Robertson and Obetz, Jefferson City, Mo. This column provides an overview of legal issues and is not a substitute for the advice of qualified legal counsel.